



Cross Border Cooperation Health in Ireland

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Cross-Border Cooperation Health in Ireland

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ABSTRACT

Providing healthcare services commands the largest allocation of public funding on both sides of the Irish border and concerns over the efficiency and effectiveness of these systems are perennial. Over the past two decades health has been identified as a key area for cross-border collaboration. However, in the absence of an overarching framework or strategy, there is little clarity about objectives. Using the responses to the COVID-19 pandemic as a case study it demonstrates that even in the face of an existential crisis, political leaders default to debates over culture and identity. The paper sets out how the healthcare systems in the two jurisdictions share similar core principles and values and face similar social, economic and political pressures. They

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have adopted broadly comparable approaches to tackling systemic issues, such as an ageing and growing population, evolving healthcare needs, workforce planning and financial pressures. It argues that there is potential for greater cross-border cooperation but this requires high-level political agreement and must be based on robust evidence. As this paper shows, there are significant barriers to developing all-island approaches, but these are not insurmountable.

INTRODUCTION

Over the past two decades health has been identified as a key area for cross-border coordination. Theoretically, closer cooperation could deliver economies of scale, value for money, opportunities for clinical specialisation and the sharing of knowledge and good practice. This type of collaborative activity would particularly benefit communities that straddle the border where services are often difficult to access. While on paper the benefits of collaboration are obvious, creating this dynamic across the constitutionally separate parts of this island is challenging and not supported by extensive evidence or research. Significantly though, the regular and repeated calls for further collaboration and cooperation have not been accompanied by any detailed plans, feasibility studies or robust data to support an all-island approach. Statements by political parties and policymakers urging improved cross-border working are expressed in general, vague terms. To date the approach has been minimalist and often project specific. Recent major policy reviews on both sides of the border have paid scant regard to this issue. There are major structural and financial differences between the health systems in Northern Ireland and the Republic of Ireland. However, they share similar core principles and values and face similar social, economic and political pressures.¹ To a large extent they have adopted broadly similar approaches to tackling systemic issues. Key challenges include an ageing and growing population, evolving healthcare needs, workforce planning, rising costs associated with medical technology and increasing expectations.

When compared to other European countries, both jurisdictions have poor population health outcomes. The main causes of premature deaths are the

¹ Jim Jamison *et al.*, *Cross border co-operation in health services in Ireland* (Armagh, 2001).

same: cardiovascular disease, cancer, accidents and suicide. Given the dominance of healthcare issues in the politics of Ireland, north and south, the lack of knowledge and research is extraordinary. While this may be partly explained by the political sensitivities of all-island working, particularly for unionists, it does not explain why the potential benefits and barriers have not attracted substantial research attention. This article assesses the nature and extent of cross-border healthcare with particular reference to the differing approaches to tackling COVID-19. It illustrates that in many ways the responses to the pandemic provide a useful case study for research into the politics of health on this island. It also assesses issues of convergence and divergence, difficulties with comparative analysis, and outlines the ways in which the response to the coronavirus has been informed by experiences of Brexit with political divisions shaping decision-making and the direction of policy.

THE PANDEMIC

Beginning with a cluster of pneumonia cases from a disputed source in Wuhan, China, COVID-19 has spread across the world with alarming speed and has become the defining health crisis of our time. Although we are physically distancing as individuals, the need to work collectively and in a coordinated way has never been more apparent. This pandemic recognises no borders and does not discriminate, is a phrase that has been used repeatedly in reference to the politics of an all-island response to COVID-19. While it could be contended that geographic considerations meant that Ireland was ideally placed to cooperate in the area of public health, the political realities were far from conducive to collaboration. This pandemic struck just two months after the restoration of devolution in the north following a three-year hiatus. The Brexit imbroglio added to already strained relationships between the parties and trust and confidence were in fairly low supply. In the Republic of Ireland, a caretaker government headed by Taoiseach Leo Varadkar was leading the country in the wake of an inconclusive election in early February.

Initial responses

At the outset the Northern Ireland Executive presented a united front and assured the public that the massive challenges presented by COVID-19 would be tackled jointly as the virus had no political consideration; it was neither

unionist nor nationalist. This was a significant moment both practically and symbolically, an agreement that party politics would be set aside for the overriding goal of saving lives. There was a recognition that a single strategy for handling the pandemic was paramount as the public were naturally confused and fearful. This united front was however short-lived. The Republic of Ireland announced that the closure of schools, pre-schools and higher education settings would take place on 12 March. Taoiseach Leo Varadkar noted that ‘Acting together as one nation can save many lives’.² On the same day in the north, the first minister and deputy first minister jointly announced that the Executive would not be moving immediately to close schools and their decision was based on the ‘scientific evidence’. Evidently, there would not be an all-island approach to combatting the pandemic. Less than 24 hours after a joint press conference, Deputy First Minister Michelle O’Neill backtracked and demanded immediate school closures.

Her ‘solo run’ was branded shameful and utterly reckless by colleagues in the Executive. The first minister, Arlene Foster, expressed disappointment, but not surprise. The Ulster Unionist Party leader, Steve Aiken, accused the deputy first minister of causing ‘more fear and uncertainty’. He alleged that the move fundamentally undermined the integrity of the Executive. The emphasis was firmly on two jurisdictions rather than a unified approach. The health minister, Robin Swann, told Stormont’s health committee that deaths should be expected in Northern Ireland, but so far it was ‘not in the same place’ as the republic. Our approach is ‘different’, he stressed. The prospect of diverging strategies caused widespread dismay among the public who feared party politics was being prioritised over public health. Was it really being suggested that the coronavirus would respect the 310-mile border between the north and south of Ireland? Sinn Féin and the DUP’s instinctive defaulting to their constitutional positions when devising their responses to the pandemic was predictable and depressing in equal measure. In a tweet later reported in *The Guardian*, the unionist political commentator Alex Kane expressed his frustration and disbelief at the inability to set aside political differences in the face of a global health emergency: ‘Since coronavirus doesn’t give a damn about borders or identities it makes sense for Northern Ireland to follow immediately’.³

² *Irish Times*, “‘Acting together, as one nation, we can save many lives”, says Varadkar”, 12 March 2020.

³ Rory Carroll, ‘Ireland school closures reveal stark contrast to UK COVID-19 response’, *The Guardian*, 12 March 2020.

It was quickly apparent that the first minister and leader of unionism was determined to slavishly follow Boris Johnson's approach, despite the fact that it inexplicably differed from World Health Organisation guidance. The PM's policy miscalculation on herd immunity, a refusal to participate in an EU ventilator purchasing scheme, a lack of PPE and failure to test, trace and isolate attracted sustained criticism. Despite this, the DUP initially appeared determined to stick rigorously to the British approach and refute suggestions that an all island approach was either desirable or justified. In the face of a global pandemic the first minister repeatedly demonstrated an unwillingness and inability to break out of her unionist straitjacket. Conversely, her partners in government Sinn Féin stressed the need to adopt an all island approach with testing at the core of the battle against the virus. In a tweet following a joint press conference, Michelle O'Neill castigated the Department of Health over a lack of testing and PPE and stressed 'as a political leader I have called this out'. Further cracks emerged when the Department of Health decided to follow the lead of Whitehall and abandon community testing—ignoring the World Health Organisation's mantra of 'test, test, test'. This decision was reversed months later when UK officials admitted they got it wrong and testing was resumed. While no political party would openly use the health emergency to score political points, it is clear that Northern Ireland's first minister sought to assert the separateness of Northern Ireland from the republic, while Sinn Féin argued for convergence.⁴ Overcoming the deep political divisions, at least temporarily, and collaborating even when their constituents' lives were at risk, presented huge difficulties for parties conditioned to prioritise constitutional and ethnonational considerations. Decision making around the virus highlighted once again the fragile foundations of politics in Northern Ireland.⁵

Just days after the politicisation of the virus appeared to scupper any hopes of a united approach, a more coordinated strategy was agreed. On 14 March senior ministers from the Northern Ireland executive—the first minister, deputy first minister and health minister—met in Armagh with the taoiseach, the tánaiste and minister for health from the Irish government, alongside their respective chief medical officers to discuss north-south cooperation on COVID-19. A statement released by Northern Ireland's Executive

⁴ Barry Colfer, 'The COVID-19 pandemic on the island of Ireland', *The UK in a Changing Europe*, 31 March 2020, available at: <https://ukandeu.ac.uk/the-covid-19-pandemic-on-the-island-of-ireland/> (13 October 2020).

⁵ Dan Haverly, 'Not even coronavirus can overcome Northern Ireland's divisions', *Foreign Policy*, 24 April 2020, available at: <https://foreignpolicy.com/2020/04/24/coronavirus-northern-ireland-divisions-sinn-fein-dup/> (13 October 2020).

Office noted: 'It was agreed that everything possible will be done in coordination and cooperation between the Irish Government and the Northern Ireland Executive and with the active involvement of the health administrations in both jurisdictions to tackle the outbreak'.⁶ The administrations in Northern Ireland and the Republic of Ireland accepted the need to work closely together on the COVID-19 crisis.

As the island of Ireland is a Single Epidemiological Unit (SEU) for disease control relating to animal health, it seemed that similar practical considerations would pertain to the spread of human diseases such as COVID-19.⁷ As agreed at the meeting, the health departments in Northern Ireland and the Republic of Ireland signed a Memorandum of Understanding.⁸ This committed 'to promote cooperation and collaboration in response to the COVID-19 pandemic'. They committed to working together on a number of key areas including:

- modelling the spread and impact of COVID-19
- the development of public health messages
- sharing information on measures such as testing, contact tracing and social distancing
- adopting consistent common messages where appropriate, such as on handwashing, hygiene and social distancing
- behavioural change, research and ethical frameworks
- cooperation in the area of research

Alongside this it was announced that the chief medical officers of Northern Ireland and the Republic of Ireland agreed to hold a weekly teleconference to update each other on the situation in their respective areas and 'ensure mutual ongoing understanding'. Significantly, with reference to the development of

⁶ Northern Ireland Executive Office, 'Meeting of Irish Government and Northern Ireland Executive ministers concerning north-south cooperation to deal with COVID-19', 14 March 2020, available at: <https://www.executiveoffice-ni.gov.uk/news/meeting-irish-government-and-northern-ireland-executive-ministers-concerning-north-south-cooperation> (13 October 2020).

⁷ Jess Sargeant, 'North-south cooperation on the island of Ireland', Institute for Government, 1 July 2020, available at: <https://www.instituteforgovernment.org.uk/explainers/north-south-cooperation-island-ireland> (13 October 2020).

⁸ Department of Health, Ireland, and Department of Health, Northern Ireland, 'Memorandum of Understanding, COVID-19 Response', 7 April 2020, available at: <https://www.health-ni.gov.uk/sites/default/files/publications/health/MOU-NI-RoI-Covid-19.pdf> (13 October 2020).

public health responses, the memorandum also states that: ‘Consideration will be given to the potential impact of measures adopted in one jurisdiction [or] the other recognising that the introduction of such measures may differ reflecting differences in COVID-19 transmission at different stages of the public health response’. Professor Mike Tomlinson suggested this statement was in fact evidence that the island of Ireland had been accepted as two epidemiological units, thereby foregoing the opportunity to exploit the potential for cross-border cooperation.⁹ Martin Unfried and Anthony Soares, meanwhile, suggested that the memorandum acknowledged the value of analysing the impact of any policies on the other jurisdiction, as public health measures introduced on one side of the border have clear implications for all citizens on the island.¹⁰ It was important to acknowledge that people will naturally want to understand why governments on either side of the border are acting in particular ways, especially if there was significant divergence between the two jurisdictions. It was completely predictable that fears could be magnified on the island of Ireland, where citizens in Northern Ireland, for example, may seek reassurance that the approach taken by the devolved government was on the basis of scientific evidence and not just politically motivated.

The memorandum between the health authorities of the two jurisdictions notes that cooperation in response to COVID-19 will build on ‘existing and long-established cooperation on the island of Ireland between the Participants and the health services including across cancer, ambulance and congenital heart services, and the strong pre-existing cooperation between the offices of the Chief Medical Officers in both jurisdictions’. While cooperation across the border in the area of healthcare does already exist, it is however relatively limited with no proposals for significant expansion. North-south collaboration in healthcare has evolved in response to patient need, both in border areas and on an all-island basis. Many services are not underpinned by European Regulations, for example, the All-Island Congenital Heart Disease Network and the North West Cancer Centre at Altnagelvin are based on inter-governmental agreements between the respective health departments north and south, underpinned by Service Level Agreements.

⁹ Michael Tomlinson, ‘Coronavirus: Ireland is one island with two very different death rates’, *Irish Times*, 22 April 2020.

¹⁰ Martin Unfried and Anthony Soares, ‘Briefing paper: Approaches to the COVID-19 pandemic: Bordering on (non) cooperation’, Centre for Cross Border Studies, 2020, available at: <https://crossborder.ie/briefing-paper-approaches-to-the-covid-19-pandemic-bordering-on-non-cooperation/> (13 October 2020).

Following the Brexit transition period, it is envisaged that these will continue on the basis of a bilateral agreement between the UK government and the Republic of Ireland.¹¹

Health in Northern Ireland is a fully devolved issue and there has been extensive debate and disquiet about the rationale for following the Whitehall position rather than assessing national and international evidence and delivering a bespoke model for Northern Ireland. One key advantage of devolution is the ability to formulate policies tailored to local needs and priorities.¹² The British government, like almost every other government worldwide, was seriously unprepared for this global emergency. However, the problem, particularly in the crucial initial phases, stemmed from an underestimation of the threat combined with breath-taking complacency. Fintan O'Toole has suggested that the coronavirus has exposed the myth of British exceptionalism which had also underpinned the approach to Brexit. He contends that this idea of exceptionalism helps to explain the belief that there should be a distinctive British policy response to the virus. According to him this highly delusional ideology helps to explain the slowness of the response, the decision to pursue the discredited herd immunity and the idea that the World Health Organisation was only relevant to low or middle-income countries.¹³ The devolved government had the power and ability to chart its own course rather than blindly following the British government's shambolic, counter-intuitive policies.

THE NORTH SOUTH MINISTERIAL COUNCIL

Health is already an established area of north-south cooperation. The North South Ministerial Council (NSMC), established under strand two of the 1998 Good Friday Agreement, brings together the two governments on the island of Ireland to 'develop consultation, cooperation and action within the island of Ireland', and has health as one of the six agreed areas of cooperation. On his first visit to the north as taoiseach in mid-July, Micheál Martin agreed

¹¹ Northern Ireland Audit Office, 'The UK border: how prepared is Northern Ireland for exiting the EU?', 2018, available at: <https://www.niauditoffice.gov.uk/sites/niao/files/media-files/Final%20Brexit%20Report.pdf> (13 October 2020).

¹² Deirdre Heenan and Derek Birrell, *The integration of health and social care in the UK: policy and practice* (London, 2018).

¹³ Fintan O'Toole, 'Coronavirus has exposed the myth of British exceptionalism', *Irish Times*, 11 April 2020.

to convene a meeting of the North South Ministerial Council at the end of the month. As agreed, the NMSC met in Dublin on 31 July. It was the first time that the council had met in three years as it went into abeyance during the three-year collapse of the devolved structures in Northern Ireland. The council acknowledged the development of a Memorandum of Understanding on public health cooperation on COVID-19 and welcomed what was termed the ‘close productive cooperation’ that had taken place between the key personnel, north and south, to ensure an effective public health response.¹⁴ Ministers noted the impact of the pandemic on the administrations north and south and agreed to continue to collaborate in the future. It was reported that they discussed ways of improving cooperation to tackle the pandemic but nothing concrete was agreed and no further details of what was discussed were released. Notwithstanding these warm honeyed words, collaboration and coordination had been limited and somewhat perfunctory. Despite the fanfare, this meeting appeared to be going through the motions rather than agreeing any substantial strategic changes in policy or practice.

STATISTICS AND DATA

A key issue to emerge from this pandemic has been the accessibility, reliability, generalisability and robustness of the available data and the extent to which meaningful comparisons can be made across the north and south of this island. Epidemiological data are paramount to targeting and implementing evidence-based responses to protect the public’s health and safety.¹⁵ Nowhere are data more important than epidemiologic investigations designed to understand and prevent the spread of a deadly pandemic. A longstanding issue in terms of all-island comparative research has been the limitations of the data. Allowing the data to be published is not about restricting the ability to pursue differing agendas, but about holding governments to account, learning from divergence, ensuring value for money and improving outcomes. This issue is

¹⁴ North South Ministerial Council Joint Secretariat, ‘North South Ministerial Council Twenty-Fourth Plenary Meeting, Dublin Castle, 31 July 2020, Joint Communiqué’, available at: https://www.northsouthministerialcouncil.org/sites/northsouthministerialcouncil.org/files/publications/Twenty%20Fourth%20Plenary%20Joint%20Communiqu%C3%A9%20-%20Dublin%2031%20July%202020_1.pdf (13 October 2020).

¹⁵ Katrina Hedberg and Julie Maher, ‘Collecting data’, CDC Field Epidemiology Manual, Centres for Disease Control and Prevention, 2018, available at: <https://www.cdc.gov/eis/field-epi-manual/chapters/collecting-data.html> (13 October 2020).

of course not limited to cross-border research. Making comparisons across the four countries of the UK is beset by seemingly intractable problems.¹⁶

Comparisons are crucial and the British prime minister's assertion that he was not interested in cross-country analysis of coronavirus was treated with a mixture of disbelief and dismay. Comparisons between countries such as Germany and Spain allow an assessment of the effectiveness of differing national responses and can then inform the formulation of best practice. Comparative assessments using health statistics and data from both parts of this island are far from straightforward. However, notwithstanding the difficulties associated with statistics, they should be a key part of the debate about policies and outcomes. In this context a culture of transparency and accountability is crucial to ensure that policy is evidence based.

Concerns around transparency and accountability with the Department of Health in Northern Ireland are longstanding. Previous attempts at comparison across the four countries of the UK have been hampered by data that is not directly comparable.¹⁷ In their study of health and social care in Northern Ireland, Dayan and Heenan noted that the prevailing culture in the Department of Health was one of 'a siege mentality'.¹⁸ The authors describe a culture of opposition to external scrutiny and oversight, a rigid top-down culture characterised by command and control. They note how they 'experienced repeated and explicit refusals to engage with our work from senior officials. This went far beyond anything we have ever experienced in often challenging and critical research of the NHS'.¹⁹ This unwillingness to engage in independent scrutiny was not just implicit but also extended to circular emails to 'discourage' large groups of senior figures from participating.

Throughout the pandemic concerns have been raised in the north about the data and how it has been reported. In an extraordinary intervention at the end of April the UK Statistics Authority sent a letter admonishing the Department of Health over 'gaps' in its information. The Statistics Authority said there was 'serious public concern' about changes made in the way the

¹⁶ Chris Ham *et al.* 'Integrated care in Northern Ireland, Scotland and Wales: lessons for England', The King's Fund (London, 2013), available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/integrated-care-in-northern-ireland-scotland-and-wales-kingsfund-jul13.pdf (13 October 2020).

¹⁷ Ham *et al.* 'Integrated care'.

¹⁸ Mark Dayan and Deirdre Heenan, 'Change or collapse: lessons from the drive to reform health and social care in Northern Ireland', Nuffield Trust, London, 10 September 2019, 28, available at: <https://www.nuffieldtrust.org.uk/research/change-or-collapse-lessons-from-the-drive-to-reform-health-and-social-care-in-northern-ireland> (13 October 2020).

¹⁹ Dayan and Heenan, 'Change or collapse'.

data was reported during the pandemic. The director general for regulation noted that 'Daily surveillance statistics should be released in a transparent, easily accessible and orderly way', and that 'A news release on a departmental website and Twitter are not sufficient'. Furthermore 'users should be provided with appropriate context and explanation, particularly now, where different statistics from different data sources are being produced and used in relation to COVID-19'.²⁰ This intervention was welcomed on Twitter by Professor Gabriel Scally who noted that the Department was in 'very hot water over their provision of statistics'. He had been critical of their 'dreadful performance' and suggested they had 'quite rightly' been reprimanded.²¹

This unease about the culture that prevails in significant aspects of government in Northern Ireland and the apparent unfettered power wielded by senior officials and civil servants was further fuelled by a letter from the chief medical officer (CMO) to the vice chancellor of Queen's University Belfast. The extraordinary intervention from the CMO, in which he expressed his concerns about advice on personal protective equipment (PPE) given to the media by a member of staff at Queen's, was widely viewed as an attempt to muzzle independent experts. 'Jaw dropping', 'inappropriate' and 'petty' was the verdict of Professor Luke O'Neill, of Trinity College Dublin, on the letter which referred to 'ill-informed commentary and communication'.²² In his communication, the CMO urgently requested that the vice chancellor address this issue as an internal matter and implored him to take all measures within his gift to ensure that the named academic did not give advice which was 'beyond his specific expertise'. The Alliance MP Stephen Farry suggested that the letter from the CMO marked a move into 'dangerous territory', as indeed was the attempt by the Department of Health to 'spin it'. Very quickly a statement was released from the Department of Health refuting any suggestion that there was an attempt to stifle academic opinion. This raises the question of what was the vice chancellor being asked to do? Why should experts not feel free to publicly express their opinions, particularly in a context where the CMO was unavailable for comment?

²⁰ Office for Statistics Regulation, 'Letter regarding statistical information relating to Covid-19 in Northern Ireland', 30 April 2020, available at: <https://osr.statisticsauthority.gov.uk/correspondence/letter-regarding-statistical-information-relating-to-covid-19-in-northern-ireland/> (13 October 2020).

²¹ See Gabriel Scally, 'A virus free island is within our grasp', *Irish Times*, 15 June 2020.

²² Jilly Beattie, 'QUB academic concern after virologists reportedly asked not to engage with the media during COVID-19 pandemic', *BelfastLive*, 19 June 2020.

This debate over the use of data and the challenges associated with meaningful comparisons between the responses to COVID-19 was brought into sharp relief by the reactions to an opinion piece by Prof. Tomlinson, published in the *Irish Times* on 22 April. In this influential article, he argued that rather than Ireland being considered as one epidemiological unit, different public health policies for fighting the disease had emerged on either side of the border. The question was did this divergence, with the north following Westminster and the south following the World Health Organisation, produce different results? Or more bluntly, would differing approaches result in avoidable deaths?

Prof. Tomlinson highlighted the difficulties of meaningful comparison with divergent methodologies for registering deaths on both parts of the island. However, notwithstanding these methodological constraints, the article contended that there was robust evidence of two COVID-19 death rates on the island of Ireland. Acknowledging the practical difficulties with comparative evaluations, and that there were shortcomings with the available statistics, he contended that the statistical evidence should inform the ongoing debate around policies, such as testing and tracing. Following a critique of the information available, he concluded that the republic's death rate was two-thirds of that in the north. Acknowledging that this statistic may change as the pandemic progressed, he argued that 'it is reasonable to assume that the north's higher death rates result from lower rates of testing, the lack of contact tracing and the slower application of lockdown measures compared with the Republic'. Tomlinson concluded that the difference in outcomes highlighted the need for a coordinated approach across the island to tackle the virus. This should involve increased levels of testing and contact tracing and more robust public health surveillance at points of entry.

Prof. Tomlinson's contentions ignited a substantial debate over the differing approaches and their implications for public health. Rather than welcoming a debate the Northern Ireland health minister, Robin Swann, was scathing and condemned his claims as 'misleading' and 'ghoulish'. What was particularly notable was that the main attempts to rebut his claims were not focused on public health considerations but framed in wider political considerations such as the constitutional question and the future of the United Kingdom and Brexit. Dr Graham Gudgin, Chief Economic Adviser to the London-based, pro-Brexit, right-wing think-tank, the Policy Exchange, penned a highly

critical response which was published in the *Irish Times* just two days later.²³ The economist's condescending response was largely set in the context of the constitutional question rather than public health policies. He alleged that rather than valid public health concerns the debate on the pandemic had 'boosted the war of words' around Irish unity and this was 'fuelling the contest over whether the north or south provides superior government'. After challenging Prof. Tomlinson's findings in his missive, he suggested that the comparison between both parts of the island was not particularly significant. The key point was that death rates north and south of Ireland were markedly below those witnessed by Britain. The management of the pandemic was of second order to the fact that population densities on this 'offshore island' were one sixth of those in England. Aside from the disparaging reference to Ireland as an 'offshore island', in essence he contended that public health responses were largely an irrelevance. What mattered, he opined, was the nebulous concept of population density. It is worth noting that the impact of population density on highly contagious diseases has rarely been studied. While it might appear likely that higher population density would be associated with higher transmission of the disease, it is also associated with higher levels of access to healthcare and greater adherence to social distancing measures. Initial findings from large-scale studies of COVID-19 suggest that country density is not significantly related to the infection rate.²⁴

Dr Gudgin further developed his ideas in a fifteen-page document entitled 'COVID-19 across Ireland', published by the Policy Exchange.²⁵ Bizarrely, the whole premise of the pamphlet appears to be based on the assumption that proving the death rate north and south of Ireland are broadly similar will strengthen the case for the Union. In the forward to the document, Lord Jonathan Caine, former policy advisor in the Northern Ireland Office, bemoans the fact that over the last couple of years it has become 'increasingly fashionable to assume that a united Ireland is inevitable'. He outlines three factors that have led to this 'grossly irresponsible' position, one of which is what he refers to as the 'weaponising' of COVID-19 by those who advocate the need for an all-island approach to health as a means of promoting a united Ireland. In this publication Dr Gudgin claims he has debunked any assertion that the

²³ Graham Gudgin, 'COVID-19: one island with very different death rates?', *Irish Times*, 24 April 2020.

²⁴ See Shima Hamidi *et al.*, 'Does density aggravate the COVID-19 pandemic? Early findings and lessons for planners', *Journal of the American Planning Association* 4 (86) (June 2020), 495–509.

²⁵ Graham Gudgin, 'COVID-19 across Ireland: what the data can tell us', *Policy Exchange London*, 2020, available at: <https://policyexchange.org.uk/wp-content/uploads/Covid-19-across-Ireland.pdf> (13 October 2020).

republic's response has been more sure-footed and effective. He asserts that his research proves that the death rate is broadly similar in the two jurisdictions. He states this finding is supported by health authorities north and south, an assertion that there is absolutely no evidence to support. The publication demonstrates how Brexit has politicised and toxified the British-Irish political landscape to the extent that any attempt to draw comparisons in public health responses is automatically viewed through the lens of constitutional threats.

EU FUNDING AND BREXIT

Since 1995 the region has received PEACE IV funding designed to support peace and reconciliation, and managed by the Special EU Programmes Body (SEUPB) since its establishment under strand two of the 1998 Good Friday Agreement. In the most recent round, PEACE IV invested €270m, €229m of which is provided through the European Regional Development Fund, and the remaining €41m is match-funded by the Irish Government and the NI Executive. The region has also been in receipt of INTERREG funding since 1991, representing an investment of approximately €1.13 billion in territorial cooperation.

Additionally, the content of the current INTERREG VA programme has four core objectives which include providing health and social care services on a cross-border basis, which ideally will be mainstreamed into core services after the funding period. Various services have been established through INTERREG funding and rolled out by Cooperation and Working Together (CAWT), including the Multiple Adverse Childhood Experiences programme, which secured €5.01 million, and the Acute Hospitals Services project 'Connecting Services, Citizens and Communities', which secured €10 million. Since 1992, CAWT and their partners have been collaborating and working together in the border region of Ireland and Northern Ireland in support of national government and both health departments' priorities. The CAWT Partnership geography spans the entire border region, accounts for 25 per cent of the total area of the island of Ireland and has a population of 1.6 million. The project designs practical and innovative solutions to the health and social care needs of the border region. This valuable EU investment, through the INTERREG VA's health theme, and amounting to a total of €36 million across all projects for all areas, has provided the CAWT partners

with a unique opportunity to further intensify and embed cross-border health and social care activity. The CAWT Partnership has reiterated a belief and optimism that any post-Brexit agreements will not impede these now firmly established existing cross border and all-island health and social care arrangements and future developments.²⁶

The SEUPB recently clarified that even in the event of a no-deal Brexit, funding under the current PEACE and INTERREG programmes will continue until their conclusion in 2023. It is anticipated that funding programmes will continue after Brexit through a single PEACE PLUS programme as part of the EU funding budget for 2021–27. The UK government has given their commitment to the PEACE PLUS programme and it is currently envisaged the necessary funding will be available irrespective of how the UK exits the EU.

A NEW IRELAND

Following the vote by the UK to leave the EU in 2016, the increased likelihood of a border poll has been widely accepted as an inevitable consequence of this decision. It is further asserted that forcing the north to leave the EU when the majority voted to remain will ultimately hasten the creation of a united Ireland. While the extent to which this assumption is correct is debatable, it is indisputable that in the post-Brexit discussions of the future of this island, healthcare has moved to centre stage. On 21 September, when answering questions on the July meeting of the North South Ministerial Council (NSMC), Michelle O'Neill stated that an expansion of cross-border provision could help reduce Northern Ireland's 'dire' waiting lists. Further stating that she was 'quite sure' there were avenues to work across the island to enable people to get the treatment that they deserve. There is no disputing the fact that waiting lists in Northern Ireland have spiralled out of control, with as of June 2020 over 136,000²⁷ people waiting for their first out-patient consultant appointment, an increase of 30,000 compared to same time last year. In his 2016 review of health and social care in Northern Ireland, Professor Bengoa stated that a pre-requisite for transformation of the system was securing the

²⁶ CAWT [Cooperation and Working Together], *Annual Progress Report 2018*, available at: https://cawt.hscni.net/download/doc_library/corporate/CAWT-APR-2018-FINAL_2.pdf (13 October 2020).

²⁷ DHSSPS [Department of Health, Social Services and Public Safety], *Publication of the Quarterly Northern Ireland Waiting Times Statistics*, August 2020.

trust of the public by addressing the waiting lists.²⁸ In the subsequent five years since the publication of his report waiting lists have risen exponentially. Significantly, the NI Executive has not produced a plan or a strategy to address this crisis and has lost control of the waiting lists.²⁹ To simply call for further cross-border collaboration to address this fundamental issue in the absence of any strategic response from those holding the reins of power is meaningless grandstanding.

Attitude surveys repeatedly illustrate that access to healthcare is highly valued by people across this island. In the north, inclusion in the NHS with services free at the point of delivery is identified as one of the key benefits of being part of the United Kingdom. Until recently even the most zealous republican could not dispute the value of the NHS. The received wisdom for decades has been that the healthcare system in the north is far superior to that of the south. There are persistent and growing problems in the healthcare systems on both sides of the border. Many who support the idea of reunification would balk at the idea of paying to see a GP or paying for prescriptions. However, parts of the healthcare system in the north have effectively collapsed and the differences between both systems are complex and may be further complicated by Brexit. The reality of the waiting lists in the north mean those who require elective care either pay for it or languish for years on a waiting list. The dreaded two-tier healthcare system has arrived by stealth. Unionists can no longer be assured that the NHS is viewed as an immutable asset. NHS spending per head of population varies between the four nations of the UK, it is highest in Northern Ireland, but the region has the poorest health outcomes. The republic's complex funding system with a relatively high reliance on private healthcare is poorly understood and generally perceived negatively. There is no doubt that in any future border poll, the funding of and access to healthcare will be a significant issue. Those advocating for change will have to convince people that leaving the NHS will not be detrimental to their health and well-being.

²⁸ DHSSPS, *Systems, Not Structures: Changing Health and Social Care* (Belfast, 2016).

²⁹ Dayan and Heenan, 'Change or collapse'.

CONCLUSION

The COVID-19 crisis is still unfolding; to date though it has demonstrated examples of positive working and highlighted underlying tensions and volatility. The sharply divergent policies of the British and Irish governments presented a serious threat to the newly formed government in Northern Ireland. Sinn Féin looked to the Irish Government for advice and support and emphasised the advantages of viewing the island as a single epidemiological unit. Unionists were uncomfortable with an all-island approach and took their lead from London. Even in the face of an existential crisis, the political leaders in Northern Ireland defaulted to their engrained positions on the constitution and identity to devise their responses to the pandemic.

The approaches to COVID-19 have highlighted the deep political divisions that exist on this island. Whilst across the world politicians have set aside enmity and collaborated in the face of unprecedented challenges, here it seems that not even in a global pandemic, in a matter of life or death, will healthcare considerations supersede identity and constitutional issues. After a rocky start the parties in the north developed something akin to a joint approach, although the row over breaches of social distancing regulations at a republican funeral has demonstrated the tenuous nature of this arrangement. Brexit has placed a huge strain on Anglo-Irish relations, there are historically low levels of trust between Dublin and Belfast and polarisation between the main unionist and nationalist parties in Northern Ireland. Exiting the European Union has evoked acute political sensitivities, resurrected old demons and created a very challenging, toxic backdrop for all-island collaboration. The public health response to COVID-19 illustrates vividly how entrenched political ideologies can negate the geographical advantages of sharing a small island. From a healthcare perspective having two largely separate regimes on one island appears counter-intuitive.

Obviously, there are fears that an all-island approach will undermine current constitutional arrangements; however, the reality is that we share one landmass. It is also noteworthy that when previously faced with a major crisis the Dublin government naturally turned first to their near neighbours in London for advice and support. In this instance Westminster was completely bypassed in favour of Brussels and Geneva. Brexit has fundamentally altered the dynamic between Dublin and London. The Republic of Ireland now views itself as first and foremost a member of the European Union and this is where support, solidarity and advice will be sought.

Cross-border health is a woefully underdeveloped area of public policy and there appears to be little appetite to address this by the administrations from either side of the border. Aside from the notable exceptions of the Congenital Heart Disease Network and the North West Cancer Centre at Altnagelvin, there is relatively little activity in this key policy area. The respective focus on internal pressures faced by poorly performing healthcare systems means that enhancing collaboration and cooperation and coordination is afforded a low priority. In their 2011 report for the Centre for Cross Border Studies,³⁰ Shane McQuillan and Vanya Sargent concluded that there was a range of potential benefits to be gained from increased north-south cooperation in healthcare. They identified a number of key acute healthcare services including cystic fibrosis, Ear Nose and Throat (ENT) surgery, paediatric cardiac surgery, orthopaedic surgery and acute mental health services that would particularly benefit from collaboration. The report also suggested that the Erne Hospital in Enniskillen presented substantial opportunities for innovation in respect of service provision on a cross-border basis. Working together to address major health issues has the potential to deliver significant additional gains for the population of each jurisdiction, which could not be achieved by each system working in isolation and so much more could be done. At the beginning of June 2020, the north's health minister launched his 'Framework for Rebuilding Health and Social Care'.³¹ Acknowledging that the health and social care system was in very serious difficulties long before the pandemic, he stressed that the virus had multiplied the challenges and pressures. This document is a misnomer, it is neither strategic nor a framework. It does not address the fundamental issues including waiting lists, workforce planning, social care reform, technological advancements, prevention, and cross-border collaboration does not merit a mention.

Formal systems to support and facilitate knowledge exchange across this island are underdeveloped and limited. Currently shared learning and collaboration is largely *ad hoc* with little attempt to share good practice. Consequently, it is unclear which areas of healthcare would benefit most from increased cooperation and what are the main barriers preventing strategic developments. There has been considerable uncertainty about the

³⁰ Shane McQuillan and Vanya Sargent, *Unlocking the Potential of Cross-Border Hospital Planning on the Island of Ireland: A Prototype Modelling Framework* (Armagh, 2011), available at: <https://www.crossborder.ie/pubs/2011-cross-border-health.pdf> (13 October 2020).

³¹ Department of Health, *Rebuilding Health and Social Care Services: Strategic Framework*, available at: <https://www.health-ni.gov.uk/sites/default/files/publications/health/rebuilding-hsc.pdf> (13 October 2020).

nature and purpose of the new Shared Island Unit established within the Department of the Taoiseach. This Unit could provide a significant vehicle to undertake much needed research on opportunities for future cooperation and alignment in the area of health and social care. An evidence base setting out the opportunities and barriers to future collaboration would help to inform the development of policies and strategies. Political differences particularly around Brexit have weakened trust and reinforced a reluctance to share data, evidence and policy tools. However, it is inconceivable that post-COVID-19 there would not be a concerted effort to develop more integrated public health policies across this island. Issues such as tackling obesity or promoting well-being could be addressed through all-island messaging and campaigning. The two governments could give this issue some momentum by establishing an All-island Health Committee. Part of its remit could be to produce independent papers on possible areas of collaboration including procurement of services, specialisms, data system, staff training and the sharing of knowledge. Ideally these would provide a series of options and provoke informed public debate and discussion.

In the context of the island of Ireland, advocating a cross-border approach in healthcare is politically divisive and can be construed as a means of promoting a united Ireland by the back door. Anyone making the case for an all-Ireland approach to healthcare is savaged by some sections of political unionism and accused of promoting a 'pan-nationalist agenda'. However, assertions about the benefits of an all-island approach are liberally employed by nationalist politicians with little or no underpinning evidence to support them. Debates on collaboration within nationalism rarely move beyond a benign motherhood and apple pie approach. Similarly, unionists extol the virtues of the NHS with scant reference to its glaring shortcomings. There are serious cracks in the NHS that are growing larger the longer they are left unaddressed. It is haemorrhaging money and resources due to an unwillingness to transform models of service delivery. Targets have been rendered meaningless and waiting lists are just lists that get longer every quarter. Patching and mending with sticking plasters will no longer suffice, a long-term strategy for improvement is required. Politicians are terrified of a negative public perception around their handling of healthcare as they know it could cost them their job. Evidence-based assertions about both healthcare systems are largely absent from the debate.

Meaningful collaboration and cooperation must be underpinned by a robust evidence base. What works and why? With reference to COVID-19

it was fairly straightforward to make international comparisons between national governments such as France and Germany but much more difficult to make comparisons between the north and south of the island. Rather than welcoming this type of activity as informative and essential, in the north this type of modelling is actively discouraged, dismissed or castigated. In the republic, it is largely viewed as marginal to the 'real' issues confronting healthcare, hardly a context conducive for building a sustainable, efficient, flexible healthcare system that meets the needs of all of its citizens. From the perspective of anyone interested in policy, politicians, civil servants, academics, policy advisers, service-users, the experiences around COVID-19 present a unique opportunity to share learning and establish what works in the divergent approaches. The reality is any meaningful comparisons are hindered by a lack of comparable data, lack of structures to facilitate shared learning and political reluctance to engage in meaningful comparison. So much more could and should be done. Politicians in both jurisdictions must grasp the nettle and make a concerted effort to create an environment that prioritises open learning, data sharing and identifying opportunities and barriers to knowledge sharing. And alongside this, build capacity and mainstream cooperation, and develop the infrastructure and environment needed to underpin effective proactive collaboration.

Read a response to this article,
'A Crowded Stage' by Anne Matthews,
<https://doi.org/10.3318/ISIA.2021.32b.11>